

# Episode Quality Improvement Program

## (EQIP) Specifications

Program Year 1

V1 - July 9, 2021

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.maryland.gov



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### 1. Background and Overview

Maryland's Health Services Cost Review Commission (HSCRC) has set all-payer rates for the State's hospitals since 1977, through a waiver with the Centers for Medicare & Medicaid Services (CMS). In 2019, Maryland entered into an agreement with CMS to modernize its rate setting authority. The Total Cost of Care (TCOC) Model was designed to build on achievements made through the Maryland All-Payer Model (2014-2018). The TCOC Model contains three core programs: The Hospital Payment Program, Care Redesign Program (CRP), and the Maryland Primary Care Program. The Episode Quality Improvement Program (EQIP) is operated by the HSCRC as one track under the CRP. EQIP is a voluntary program to engage non-hospital Medicare providers and suppliers in care transformation and value-based payment through an episode-based approach.<sup>1</sup>

This document contains technical specifications for EQIP Program Year 1 (PY1),<sup>2</sup> which begins on January 1, 2022 and ends on December 31<sup>st</sup>, 2022. It is intended to serve as a technical guide for those seeking to better understand how EQIP is implemented, and should not be considered an official CMS document. The methodology for EQIP episode construction closely reflects the Prometheus episode grouper.<sup>3</sup> Other aspects of EQIP are determined by CMS and HSCRC policy and the HSCRC's actuarial analysis of data from the baseline period (**Exhibit 1**). The overall methodology has been tailored to meet the goals of the TCOC Model, requirements of the CRP, and the State of Maryland's needs, unique payment structure, and technical capacity.

Prometheus Episode Grouper	HSCRC/CMS Policy	
Episode Definitions and Triggers	Target Price Methodology	
Relevant Cost Methodology and Episode Cost Determination	Incentive Payment Methodology	
	Quality Composite Score Methodology	
	Reporting and Monitoring to CMS	
	Participation Specialty Areas	

Exhibit 1.	EQIP Methodology	Derives from Both	<b>Prometheus Ep</b>	isode Group	er and the HSCRC

<sup>&</sup>lt;sup>1</sup> For more information on the Episode Quality Improvement Program, please visit our website: <u>https://hscrc.maryland.gov/Pages/Episode-Quality-Improvement-Program.aspx</u>

<sup>&</sup>lt;sup>2</sup> While this document briefly mentions future program years, these specifications apply only to EQIP PY1. Future details and program year updates will be published as updates to this document.

<sup>&</sup>lt;sup>3</sup> For more information on the Prometheus episode grouper, please visit: CHANGE Healthcare – Prometheus Analytics. Deeper Dive. <u>http://prometheusanalytics.net/deeper-dive</u>



### 1.1. Background

Under the TCOC Model CMS excludes Maryland providers from participating in certain Center for Medicare and Medicaid Innovation (CMMI) models. The TCOC Model permits the development of innovative payment models specific to Maryland under its CRP. The HSCRC developed the EQIP Program as an episodic incentive payment model for specialist physicians that will help increase participation in Advanced Alternative Payment Models (AAPM) within the State and allow for physician alignment with hospitals under the TCOC Model. EQIP is designed to meet the following goals:

- **Financial Accountability:** Increase physicians' accountability for improving quality of care and reducing healthcare spending related to episodes of care.
- **Care Redesign:** Support and encourage physicians interested in continuously transforming care to align with value-based payment policies and Maryland hospital Global Budget Revenues (GBR).
- **Clinical Data Analysis and Feedback:** Reduce episode costs by eliminating unnecessary or low-value care, shifting care to lower-cost settings where clinically appropriate, increasing care coordination, and fostering quality improvement.
- **Physician Engagement:** Shift towards physician-focused, value-based care reimbursement to create environments that stimulate rapid development and deployment of new evidence-based knowledge.
- **Patient and Caregiver Engagement:** Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode.

EQIP will provide incentive payments to Care Partners that help achieve these goals. These incentive payments will be based on both the financial performance and quality performance of Care Partners. EQIP episode costs include Medicare Parts A and B spending that is considered 'relevant' (as defined by Prometheus) to the specific type of clinical episode category.

### **1.2. EQIP Overview**

#### 1.2.1. Involved Parties

EQIP involves three parties (**Exhibit 2**): CRP Entities (the hospitals who administer the Care Partner Agreements and Incentive Payments), EQIP Entities (the entities for which performance is assessed) and Care Partners (the individual physicians who manage EQIP episodes).



Exhibit 2. The Three Parties Involved with EQIP



- Care Partners: General or specialist physicians licensed and enrolled in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) are eligible to be Care Partners. The State of Maryland will submit a list of potential providers to CMS by September 1<sup>st</sup> of the year prior to EQIP participation to verify the providers' eligibility. The State of Maryland then sends CMS a final list of eligible providers who signed a Care Partner Agreement (CPA) with a CRP Entity, to certify their participation and eligibility for Qualifying APM Participant (QP) status (Section 2.6).<sup>4</sup>
- EQIP Entities: Care Partners can participate individually in EQIP as an EQIP Entity or can join multiple Care Partners and participate together as one EQIP Entity, regardless of their professional affiliation with other organizations or legal entities (e.g., a physician group practice). EQIP Entities select the types of EQIP episodes for which they are to be held accountable through the EQIP Entity Portal (see Section 2.1). Note that a Care Partner is only eligible to participate in one EQIP Entity and for enrollment, each EQIP Entity will need to elect a lead Care Partner to establish the EQIP Entity and enroll through CRISP (Section 2.1). Incentive payments will be based on the aggregate performance of an EQIP Entity's Care Partners. The EQIP Entity will determine how any incentive payments that they achieve are distributed among its Care Partners.
- CRP Entities: A CRP Entity is a hospital that facilitates Care Partner participation by aggregating CPAs and issuing the incentive payments to the payment remission source indicated by their EQIP Entity.
   EQIP will require eligible Medicare providers to participate as Care Partners through CPAs with a CRP Entity. The HSCRC will support the CRP Entity through reporting following the CRP calendar

<sup>4 &</sup>lt;u>https://qpp.cms.gov/apms/advanced-apms</u>



schedule,<sup>5</sup> including metrics that provide high-level overviews of EQIP Entity performance, participation, and incentive payments. For PY1, the University of Maryland Medical Center (UMMC) is the CRP Entity for all statewide Care Partners and EQIP Entities. Any eligible Care Partner will be able to participate in EQIP, regardless of previous relationship, current contracting or proximity to UMMC.

### 1.2.2. Clinical Episode Categories

EQIP PY1 will include 15 Prometheus clinical episode categories that span three clinical specialty categories (**Exhibit 3**): Orthopedics, Cardiology, and Gastroenterology. Future PYs will include additional specialty categories, as feasible. Maryland will not compel EQIP Entities to participate in all clinical episode categories within a specialty area. EQIP Entities can choose to participate in one or more clinical episode categories within one specialty area, or multiple clinical episode categories across more than one specialty area. However, EQIP Entities are required to meet a minimum clinical episode-volume threshold to be eligible to participate in each type of EQIP episode.

Specialty Areas in PY1	Cardiology	Gastroenterology	Orthopedics
	Pacemaker / Defibrillator – Procedure, 30 days	Colonoscopy – Procedure, 14 days	Hip Replacement & Revision – Procedure, 90 days
	Acute Myocardial Infarction – Acute, 30 days	Colorectal Resection – Procedure, 90 days	Hip/Pelvic Fracture – Acute, 30 days
Prometheus	CABG &/or Valve Procedures – Procedure, 90 days	Gall Bladder Surgery – Procedure, 90 days	Knee Arthroscopy – Procedure, 90 days
Clinical Episode Category - Type, Lengths	Coronary Angioplasty – Procedure, 90 days	Upper GI Endoscopy – Procedure, 14 days	Knee Replacement & Revision – Procedure, 90 days
			Lumbar Laminectomy – Procedure, 90 days
			Lumbar Spine Fusion — Procedure, 180 days
			Shoulder Replacement – Procedure, 90 days

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<sup>&</sup>lt;sup>5</sup> https://hscrc.maryland.gov/Documents/Modernization/CRP%20Calendar%20PP6%20Final.pdf



### 1.2.3. Timeline for EQIP Milestones

The following list of dates contains important milestones in preparation for EQIP PY 1:

June 2021	Recruitment and EQIP Outreach
July 9, 2021	EQIP Entity Portal (EEP) opens for enrollment in PY1
September 1, 2021	EEP deadline for submission of Care Partners (NPIs) for CMS vetting, CRP Entity contracting, and episode selection process begins
October 1, 2021	PY1 CMS Vetting Results Available in EEP Care Partner Arrangement (contracting) begins
December 15, 2021	Care Partner Arrangement (contracting) ends, EQIP Entity participation and rosters final
January 1, 2022	EQIP PY1 begins, Episode elections are final

Note: Dates are subject to change.

### 2. EQIP Care Partner Eligibility

To be eligible to participate in an EQIP Entity, each Care Partner in an EQIP Entity is required to:

- 1. Agree to a standard Care Partner Arrangement (CPA) indicating they will comply with the following, as they initiate clinical episodes, implement care intervention plans, and treat patients:
  - Implement allowed interventions (e.g., care delivery enhancements such as standardized care pathways or reengineered care pathways using evidence-based medicine)
  - Use Certified Electronic Health Record Technology (CEHRT)
  - Notify patients about EQIP
- 2. Pass CMS vetting for eligibility and maintain certification, this includes:
  - A check that Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is up to date and correct,
  - CMS Program Integrity verification, and,
  - Law Enforcement review.

EQIP participation involves upside-only risk for EQIP Entities. They can receive incentive payments based on improved financial performance and quality of care but are not expected to repay CMS because of inadequate performance. Participating Care Partners bill CMS and receive reimbursement for their services as normal. The CRP Entity will distribute any incentive payments achieved by the EQIP Entity after the PY ends and financial performance has been assessed. Payment is expect to occur approximately six months after the end of the PY.



### 2.1. CRISP EQIP Entity Portal

CRISP, the State Designated Health Information Exchange (HIE) for Maryland, and partners at hMetrix have developed an EQIP Entity Portal (EEP) for providers to enroll in EQIP, view data, and understand the resources available to EQIP Entities. EQIP Entities are required to enroll with CRISP in order to utilize the EEP and to participate in EQIP. There is no cost to use the EEP. Ambulatory practices have free access to CRISP. CRISP data is accessible through any Internet browser via CRISP Reporting Services (CRS).Please contact **EQIP@crisphealth.org** for EQIP application assistance or refer to the CRISP Onboarding Instructions for EQIP.<sup>6</sup>

There is an EEP User Guide available that provides technical assistance for first time users of EEP.<sup>7</sup>

Note: Starting July 9<sup>th</sup>, 2021, only enrollment and baseline data modules will be available in EEP. Ultimately, EQIP Entities will have access to a series of performance evaluation modules for accessing detailed results and ongoing performance. These performance modules will open in the spring of 2022.

### 2.2. EQIP Entity Care Partner Submission - Sept. 1 Deadline

**From July 1<sup>st</sup> through September 1<sup>st</sup>** of the year before the PY, the EQIP Entity will be required to list the names, National Provider Identifiers (NPIs), and contact information for all Care Partners who intend to participate in the EQIP Entity. After September 1<sup>st</sup>, the list of Care Partners is considered final, and will be submitted to CMS for vetting into the program. Care Partners selected for the EQIP Entity should ensure they are enrolled in Medicare and up to date with their information in the Medicare PECOS. An EQIP Entity will receive a status update on Care Partners vetted by CMS, within EEP, prior to the start of the PY (anticipated 10/1 annually).

### 2.3. Annual Episode and Intervention Elections - Dec. 31 Deadline

Prior to the start of PY1, the EQIP Entity will use EEP to select clinical episode categories and indicate the interventions they will perform. This selection becomes final on 12/31/21 at 11:59 pm and must meet minimum episode-volume thresholds discussed in **Section 2.5**. The episode and intervention selection process will reopen for PY2 on 7/1/22, and close again on 12/31/22 at 11:59 pm.

### 2.4. Care Partner Arrangements and Payment Remission Recipient

Every Care Partner that an EQIP Entity submits to participate in EQIP for PY1 will be required to sign an individual, standard Care Partner Arrangement (CPA) with the CRP Entity. CPAs will detail requirements for participation, standards established for the program, and details of the EQIP Entity with which the Care

<sup>&</sup>lt;sup>6</sup> https://hscrc.maryland.gov/Documents/EQIP%20Onboarding%20One%20Pager%20Final%20(2).pdf

<sup>&</sup>lt;sup>7</sup> https://hscrc.maryland.gov/Documents/EEPUserGuide\_20210708105643.pdf



Partner intends to participate. The EQIP Entity will provide contact information for each Care Partner they select. The EQIP Entity will also be required to indicate, in EEP, a singular Payment Remission Recipient to whom the EQIP Entity's incentive payment will be distributed, if one is achieved. The CRP Entity will use this information to generate a CPA for each Care Partner for electronic signature.

CPAs are the second key component to finalizing participation in EQIP. A Care Partner will be removed from the EQIP Entity if they do not 1) pass CMS vetting and 2) have a signed CPA. The final list of Care Partners will be updated in EEP, based on these two criteria, prior to the start of the PY. While the HSCRC recognizes having every Care Partner individually sign a CPA may be administratively complex, it is essential to meet CMS compliance requirements agreed to under the CRP Participation Agreement.

### 2.5. Minimum Episode Volume Thresholds

A sufficient volume of clinical episodes is necessary to calculate target prices with enough precision to reasonably assume that costs were reduced through efficiency, better care coordination, or quality improvement, rather than by chance. Therefore, the HSCRC requires each EQIP Entity to meet two minimum episode volume thresholds during the baseline period (CY 2019) to be eligible to participate in the clinical episode categories they choose. To be eligible to participate in EQIP:

- 1. The EQIP Entity must be attributed 11 or more *clinical episodes* within each clinical episode category during the baseline period (e.g. >11 Hip Replacements), and,
- 2. An EQIP Entity must be attributed 50 or more episodes across all clinical episode categories in which they *elect and are eligible to participate*.<sup>8</sup>

EQIP Entities that do not meet the overall 50 minimum episode-volume threshold will be excluded from participating in EQIP during the PY. EQIP Entities who do not meet the 11 minimum episode-volume threshold for a clinical episode category will be excluded from reporting and participation in those types of episodes during the PY. Two scenarios for an EQIP Entity's threshold eligibility are presented in **Exhibit 4** and **Exhibit 5**.

Clinical Episode Category	Selected	Clinical Episode Baseline Volume	Eligible for Epi. Category?	Total Clinical Episode Count
Acute Myocardial Infarction – Acute, 30 days	Yes	8	No	Ineligible for Episode, excluded from Total Episode Count

#### Exhibit 4. EQIP Entity with Volume Thresholds Eligible for Participation

<sup>&</sup>lt;sup>8</sup> EQIP Entities can choose to participate in one or more clinical episode categories within one specialty category, or clinical episode categories across more than one specialty category. They are not required to participate in every clinical episode category within a specialty category.



CABG &/or Valve Procedures – Procedure, 90 days	Yes	36	Yes	64 attributed episodes, eligible	
Coronary Angioplasty – Procedure, 90 days	Yes	28	Yes	for EQIP PY1	
Pacemaker / Defibrillator – Procedure, 30 days	No	10	No	N/A, not selected, excluded from Total Episode Count	

#### Exhibit 5. EQIP Entity with Volume Thresholds Ineligible for Participation

Clinical Episode Category	Selected	Clinical Episode Baseline Volume	Eligible for Epi. Category?	Total Clinical Episode Count
Acute Myocardial Infarction – Acute, 30 days	Yes	8	No	Ineligible for Episode, excluded from Total Episode Count
CABG &/or Valve Procedures – Procedure, 90 days	Yes	10	No	Ineligible for Episode, excluded from Total Episode Count
Coronary Angioplasty – Procedure, 90 days	Yes	40	Yes	40 attributed episodes, ineligible for EQIP PY1
Pacemaker / Defibrillator – Procedure, 30 days	No	15	Yes	EQIP Entity should consider adding this episode type to meet the Total Episode Threshold

### 2.6. QPP Eligibility Participation Requirements

CRP is an Advanced APM (AAPM) for purposes of the Quality Payment Program (QPP). The CRP Entity acts as the participating APM entity on behalf of all EQIP Entities' Care Partners. Care Partners participating in the CRP will be listed on an Affiliated Practitioner List that identifies eligible clinicians to become Qualifying APM Participants (QPs). This means Care Partners engaged in EQIP will have the opportunity to opt out of Merit-based Incentive Payment System (MIPS) in exchange for EQIP participation.

For PY1, Care Partners who qualify for EQIP participation and maintain all participation requirements throughout the year will have all of their beneficiaries attributed to the AAPM to be certified as QPs. In future PYs, as episode opportunities increase, the HSCRC will update methodologies to ensure alignment with the QP thresholds policy in the AAPM track of QPP. Care Partners who participate in 2022 will receive a lump-sum payment from CMS in 2024, based on 2023 Part B services.



### 3. Prometheus Episode Grouper Episode Construction

### 3.1. Description of Data and Sources

EQIP episodes are constructed from the Claim and Claim Line Feed (CCLF) data provided by CMS to the State of Maryland. This data file contains Medicare final action claims for all Part A and Part B services received by beneficiaries who reside in Maryland, regardless of where the services were received. The file also contains claims information on all Medicare-covered services furnished within Maryland to non-residents; however, non-residents are excluded from EQIP episode construction. The data do not include Substance Abuse and Mental Health Service Association (SAMHSA) claims.

Episode triggers and episode relevant costs are derived from Medicare FFS claims. Denied claims and claims for Beneficiaries who are enrolled in Part A only, Medicare Advantage or other group health arrangements are not eligible for EQIP, and capitation or other payments related to these beneficiaries are not part of the model. In addition, exclusions are made for beneficiaries eligible for Medicare because of end-stage renal disease (ESRD) or for whom Medicare is the secondary payer.

Final paid claim amounts, trended forward to performance year dollars as described below, are used to calculate episode expenditures. Paid claim amounts are based on services provided but are also subject to CMS adjustments for geography, quality incentives, and other factors.

#### 3.1.1 Payment Update Factors

### Medicare Beneficiaries excluded from clinical episodes:

- Non-Maryland residents
- Managed Care Enrollment
- Medicare enrollment due to ESRD

#### Medicare Parts A and B (fee-forservice) claims excluded from episode triggers or episode expenditures:

- Non-final action claims
- Denied claims
- If Medicare is not primary payer
- SAMHSA Claims

In order to ensure that baseline and performance period cost totals are comparable and reflect an accurate rate for service payments during the evaluation, all payments are trended forward to the performance year dollars prior to input in the Prometheus episode grouper. All dollar amounts shown in EQIP reports (excluding baseline experience provided during enrollment) and those used for target price determination (**Section 4** below) reflect these trended amounts. These update factors take into account inflation and the changes in Medicare payment rates year over year for each of the prospective payment system fee schedules. EQIP uses the CMS PPS market basket update factors to accomplish this. A full description of the logic used to trend payments forward is described in **Appendix A**.



### 3.1.2 Standardization of Regulated Payments

The Global Budget Revenue (GBR) system used to pay for regulated (inpatient and outpatient hospital) services fundamentally differs from the prospective payment systems used for all other Medicare services. To ensure that providers are not rewarded or held accountable for fluctuations year-over-year or within a year due to GBR adjustments, all regulated payments will be calculated at the facility level using the CMS Standardization Methodology for Allowed Amount, adjusted to account for individual providers' baseline GBR rates. These amounts will be used in the calculation of all episode payment amounts during the baseline and performance period, as well as in target price determination, for consistency and comparability. As described in Appendix A, these regulated payments also utilize a Maryland-specific update factor rather than the CMS update factors used for all other settings of care.

### 3.2. Clinical Episode Construction Overview

Services and costs relevant to trigger diagnoses or procedures will be grouped together using the Prometheus episode grouper.<sup>9</sup> Each episode will consist of the following periods:

- A Trigger, such as an index hospital stay or procedure during which the initial care was performed with an accompanying relevant diagnosis (defined by a CPT or HCPCS code for procedural episodes or ICD-10 diagnosis code for acute episodes and relevant diagnoses),
- 2) A specified look-back period to capture pre-event workup ("pre-trigger window"), and
- 3) A period following the index stay or event during which to count all costs related to the trigger ("**post-trigger window**").

The HSCRC will provide an 'Episode Playbook' overview of each episode and its construction codes upon request.

### 3.2.1 Identifying Clinical Episodes via Triggers and Episode Creation

Episode triggers are defined as procedure or diagnosis codes that, when meeting the trigger criteria, indicate an episode exists. Triggers initiate episodes based on the procedure and/or diagnosis codes found on Medicare Part A or B claims, dependent on the clinical episode category definition. EQIP episodes are identified based on definitions from the Prometheus episode grouper. Triggers will be defined using qualifying primary International Classification of Diseases, Tenth Edition (ICD-10) codes, Current Procedural Terminology (CPT) codes, or Healthcare Common Procedure Coding System (HCPCS) codes.

A Trigger code assigns a time 'window' for the start and end dates of each clinical (depending on the Clinical Episode Category definition, usually 14-180 days). Once a trigger is identified, the window will be

<sup>&</sup>lt;sup>9</sup> <u>http://www.prometheusanalytics.net/deeper-dive/concepts-and-use</u>



created utilizing the specified Clinical Episode Category's "Pre-trigger window" and "Post-trigger window" durations. **Exhibit 6** below outlines the window specifications for each of the 15 clinical episode categories included in PY1. Episodes are assigned to the performance period in which they end.

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Clinical Episode Category	Pre-Trigger Window Duration	Post-Trigger Window Duration
Acute Myocardial Infarction (AMI)	None, acute episode	30-Day
CABG &/or Valve Procedures (CXCABG)	30-Day	90-Day
Colonoscopy (COLOS)	3-Day	14-Day
Colorectal Resection (COLON)	30-Day	90-Day
Coronary Angioplasty (PCI)	30-Day	90-Day
Gall Bladder Surgery (GBSURG)	30-Day	90-Day
Hip Replacement & Hip Revision (HIPRPL)	30-Day	90-Day
Hip/Pelvic Fracture (HIPLFR)	none, acute episode	30-Day
Knee Arthroscopy (KNARTH)	30-Day	90-Day
Knee Replacement & Knee Revision (KNRPL)	30-Day	90-Day
Lumbar Laminectomy (LBRLAM)	30-Day	90-Day
Lumbar Spine Fusion (FUSION)	30-Day	180-Day
Pacemaker/Defibrillator (PCMDFR)	7-Day	30-Day
Shoulder Replacement (SHLDRP)	30-Day	90-Day
Upper GI Endoscopy (EGD)	3-Day	14-Day

### 3.2.2 Assignment of Relevant Services and Payments to Clinical Episodes

Prometheus assigns "relevant costs" to each clinical episode based on the episode and trigger definitions. Relevant costs come from claims with either a relevant diagnosis or procedure during the pre- and posttrigger windows. Each claim within the episode window associated with the patient whose care 'triggered'



an episode will be evaluated for inclusion into the episode, based on the Prometheus Episode Grouper definition and business rules.<sup>10</sup>

**Relevant Diagnoses:** These are ICD-10 diagnosis codes that could serve as a proxy to the triggering diagnosis codes (for acute episodes) and tag relevant procedure claims as relevant costs for inclusion in a triggered episode. There are two types of relevant diagnoses:

- Typical/Routine [Typical\_Cost]: Those for routine and typical care during an episode, including diagnosis codes for signs and symptoms related to the episode, aftercare, and similar conditions, as well as status codes and family history codes. These costs are based on the typical practice patterns within the episode's baseline and performance periods and are not considered to reflect savings or care reduction opportunities.
- 2. Potentially Avoidable Episode Complications [PAEC\_Cost]: Those that indicate the occurrence of a potentially avoidable episode complication during the episode window. Potentially avoidable episode complications help to determine the amount of unexplainable variation in total costs of care that could be reasonably attributed to complications under the control of Care Partners. Insight into potentially avoidable episode complications will be available in terms of cost and rates of incidence. Potentially avoidable episode complication costs are some of the main opportunity insights available to drive savings and performance.

**Relevant Procedures:** These CPT, HCPCS and ICD-10 codes tag all claims to include all services that are relevant to a given episode, but only are included in the episode if they also have a relevant diagnosis code on the claim.

These details on the overall and split between routine vs. potentially avoidable episode costs, will be available in EEP's performance management dashboards.

#### 3.2.3. Episode 'Leveling' and Payment Aggregation

The Prometheus Episode Grouper contains a proprietary relationship methodology that combines episodes associated with each other, but from different clinical categories, into the most clinically relevant category. To do this, the methodology assigns each clinical episode category a 'level' at which the episode stops including costs. Episode associations for each clinical episode category are available from the HSCRC on request, and described in **Exhibit 7**.

#### Exhibit 7. Episode Associations for Clinical Episode Categories

<sup>&</sup>lt;sup>10</sup> To learn more about Change Healthcare and our value-based care solutions, contact <u>Prometheus\_Methodology@changehealthcare.com</u>



Level	Description	PY1 Episodes that Terminate in Level
Level 1	All episodes are triggered and all service assignments occur. System Related Failure (SRF) Episodes are triggered and assembled only at Level 1.	None
Level 2	Used to merge typical associations within an episode family (e.g. cardiac, GI) and category (procedural or acute). For example, Colonoscopy following Colon Resection. Both are in the same clinical family and type of episode.	None
Level 3	Used to complete <b>Procedural</b> episodes, including all complication associations and all remaining typical associations.	13 Clinical Episode Categories*
Level 4	Used to complete <b>Acute</b> episodes, including all complication associations and all remaining typical associations.	AMI HIPLFR
Level 5	Used to complete <b>Condition/Chronic</b> episodes , including all complication associations and all remaining typical associations.	None

\* CXCABG; COLOS; COLON; PCI; GBSURG; HIPRPL; KNARTH; KNRPL; LBRLAM; FUSION; PCMDFR; SHLDRP; EGD

For PY1, all but two of the clinical episode categories are procedural episodes, meaning they terminate at Level 3. Acute Myocardial Infarction (AMI) and Hip/Pelvic Fracture (HIPLFR) are considered acute episodes and terminate at Level 4. For example, Hip Replacement (HIPRPL) episode costs (Level 3) may be combined into the acute Hip/Pelvic Fracture (HIPLFR) in Level 4 should their windows overlap.

### **3.3. Calculation of Total Relevant Clinical Episode Costs**

After a clinical episode is constructed per the process outlined in Section 3.2, total relevant costs for a clinical episode are available for each triggered episode in the period (either baseline or performance) and population (Maryland Medicare FFS beneficiaries, with noted exclusions in **Section 3.1**) of interest. Total relevant episode costs are derived in the Prometheus episode grouper as follows:

- 1. Total relevant costs for a single episode include all Medicare Part A & B claim payments for the beneficiary for services that are rendered during the episode window (**Section 3.2.1**), and,
- 2. Considered relevant per the Prometheus Episode Grouper (Section 3.2.2) to the given type of clinical episode.
- 3. Payments (or paid claims) for each type of service (inpatient, outpatient, physician, durable medical equipment, skilled nursing facility, and home health) rendered during the episode window are leveled (Section 3.2.3), and,
- 4. Finally, the total payments for all types of service from (3) above are summed to calculate the total relevant episode cost for that episode .Two totals are calculated a 'SplitCost' and 'UnsplitCost' see Section 3.6.2 below for further detail on these total amounts.



Medicare Part D expenditures are not counted as part of total relevant episode costs. Denied claims are not considered payments and are excluded prior to calculating total Relevant episode costs.

Each individual episode created by the Prometheus episode grouper is assigned a 'MasterEpisodeID' [MasterEpisodeId] containing the Episode Code (Chronic, Other, Procedural, Acute, SRF), Member ID, Trigger Type, claim number and claim line of trigger, separated by underscores. This 'MasterEpisodeID' will be used to track individual episodes for further filtering, cost splitting (as appropriate) and attribution to a Care Partner (further details in **Sections 3.6.1–3.6.3**). EQIP Entities will be able to access this output upon request, as available through EEP.

#### 3.3.1. Filtering

After individual episodes are created, a number of filters will be applied to episodes to ensure data integrity. In the Prometheus episode grouper, if any of the following are deemed to be true [T], the episode is filtered out of (dropped from) the final episode output for that period:

- **Is filtered** [IsFiltered] General flag to indicate if any filter was applied to this episode. This may include additional business logic filters (e.g. episode interaction) that are not specifically called out by the detailed filter flags described below.
- Low Age [IsAgeLow] Indicates the episode is filtered because the beneficiary age was <18 years.
- **High Age** [IsAgeHigh] Indicates the episode is filtered because the beneficiary age was >120 years.
- Low Cost [IsCostLow] Indicates the episode was in the lowest five percent of costs for episodes within that clinical episode category and is windsorised out of the dataset.
- **High Cost** [IsCostHigh] Indicates the episode was in the top ninety-five percent of costs for episodes within that clinical episode category and is windsorised out of the dataset.
- **Coverage Gap** [IsCoverageGap] For episodes which have duration Greater than 90 days, if there is a coverage gap for the episode that is greater than 32 days, the episode will be filtered out. For episodes which have duration lesser than or equal to 90 days, even one day coverage loss for the beneficiary will result in the episode being filtered.
- **Incomplete** [IsIncomplete] Removes episodes for which there is not enough data, claims or accompanying information to compare the episode.
- **Outpatient Only Episode** [IsOutpatientProceduralEpisode] Upper GI Endoscopy(EGD) and Colonoscopy(COLOS) episodes performed in the inpatient setting will be filtered out from the final data output. These procedures are almost always typically performed in the outpatient setting and, thus, when performed inpatient are too disparate from the typical care to be included in episode performance.



### 3.3.2. Split versus Unsplit Costs

The Prometheus episode grouper employs multiple assignments of services – that is, where relevant, a single service is assigned, or 'split' to more than one episode. When this occurs, the cost of the service is apportioned among the episodes, so that the total cost assigned to all of the beneficiary's episodes is the same as that beneficiary's actual payment of services or claims paid. The default apportionment is equal split: if the service is assigned to two episodes, each episode is assigned half the cost of the service. Additionally, if the service is assigned to three episodes, each episode is assigned one-third of the cost of the service, and so on. When consolidation occurs, apportionment, or the split is done in this manner for each level of assignment (**Section 3.2.3**). Where episode payment totals are displayed for EQIP, the split cost is used unless specifically stated otherwise.

#### 3.3.3. Attribution of Episodes to Providers

EQIP utilizes a "Professional Attribution" within the Prometheus episode grouper [AttributionMethodID107] using the Rendering NPI field of eligible, non-denied Medicare professional claims. This means it attributes episodes to a Care Partner, or individual NPI [AttributedProviderID], based on professional claims within the trigger window (defined as +/- 2 days from trigger claim date of service start date) and identifies claims that have the required trigger diagnosis and/or procedure codes. If more than one Care Partner/NPI could have triggered the episode, then the Care Partners are ranked based on the highest allowed dollars and the highest ranking Care Partner is attributed the episode.

EQIP episodes must be assigned to individual eligible clinicians. If a group NPI is used to populate the Rendering Provider field on a professional claim and an individual NPI is available in the Referring NPI field, the episode is assigned using the latter.

The default Prometheus episode logic does not assign acute episodes to individual clinicians. For these episodes, the same logic used to attribute episodes under ECIP is used for EQIP attribution.

### 3.4. Prometheus Episode Grouper Episode Output

Clinical episode creation during baseline and the PY will follow the same methods described in **Section 3** on each data run for the specified study period. Nine quarters (27 months) of claims from the CCLF will be analyzed to ensure complete output and runout is available to complete episodes.

Episodes are included in the period of interest if they end within the timeframe, i.e. the episode end date [EpisodeEndOn] is prior to the end of the study period. So, for the 2019 baseline period, only episodes completing their window in CY2019 are included in the output, this includes episodes that may have triggered or contain a pre-trigger window spanning dates prior to CY2019.



Once the Prometheus episode grouper output is complete for the study period of interest, the episodes move into HSCRC methodologies and calculations, per **Exhibit 1**.

### 4. Target Price Methodology

The HSCRC determines incentive payments to an EQIP Entity by comparing the split total relevant episode costs' [SplitCost] for each EQIP episode attributed to one of its Care Partners against an aggregate Target Price for that episode. While preliminary Target Prices will be available at the start of a performance year, the final Target Price used for reconciliation will not be available until the end of the PY for each EQIP Entity at the clinical episode category level.<sup>11</sup> Some other characteristics of EQIP's target pricing include:

- Target Prices are set using the baseline period split total relevant episode costs' [SplitCost], trended forward for inflation (**Appendix A**) to be comparable to current PY costs.
- Target prices are not adjusted for changes to the Care Partners' patient mix between the baseline period and the PY.
- Target Prices do not vary across care settings (e.g., hospital inpatient, outpatient, post-acute care, physician office), instead they are setting-neutral to allow for the creation of savings for shifting low acuity services to lower cost settings.

### 4.1. Calculation of Baseline Target Prices

A target price will be calculated for each EQIP Entity at the clinical episode category level, based on the combined total relevant episode costs for each clinical episode attributed to the Care Partners that constitute the EQIP Entity during the baseline period. The steps to calculate Target Prices for each clinical episode category are as follows:

- 1. Determine Average EQIP Entity Baseline Costs per Clinical Episode Category.
  - a. For each EQIP Entity [EQIP ID], sum the split total relevant episode costs [SplitCost] for all participating Care Partners using the attributed provider [AttributedProviderID] within each clinical episode category [EpisodeCode]. This will produce a single aggregate EntityAggregateEpisodeCost for each clinical episode category.
  - b. Divide the EntityAggregateEpisodeCost derived in (1a) for each clinical episode category by the total baseline volume [unique count of MasterEpisodeID] of participating Care Partners in that clinical episode category to arrive at the EntityAverageEpisodeCost for that EQIP Entity - clinical episode category combination. Note that this is simply a weighted

<sup>&</sup>lt;sup>11</sup> Because target prices have to be inflated to match performance period unit costs it is not possible to finalize target prices until all inflation amounts are known.



average of episode level costs across all episodes initiated by care partners of that EQIP Entity within the given Clinical Episode Category.

**c.** Set the Target Price for that Clinical Episode Category for that EQIP Entity equal to the corresponding EntityAverageEpisodeCost.

### 4.2 Preliminary Target Prices and Finalizing Target Prices

The **Preliminary Target Price** is equal to the EQIP Entity's average episode costs (Step c from **Section 4.1** above) during the baseline period, without risk-adjustment, trended forward to the most study period (per **Section 3.1**). Preliminary target prices will be calculated for each EQIP Entity in each clinical episode category they elect participation in during the enrollment period. The preliminary target price will be available in EEP, in the performance dashboard, when the Performance Year begins.

The **Final Target Price** for the PY is equal to the unadjusted baseline target price multiplied by without riskadjustment, trended forward to the most study period (per **Section 4.2**) Final target prices will not be adjusted for changes in the case mix of patients, geographic variation, or peer comparison. Final target prices will be calculated at reconciliation and will only be generated for clinical episode categories in which an EQIP Entity is participating.

### 4.3 Updating Target Prices over Performance Years

Target Prices will be calculated using the initial baseline year for the EQIP Entity's entrance into the program for the first three years of EQIP participation. The initial baseline year is determined based on the year the EQIP Entity enters the program:

- For EQIP Entity's entering in PY1, 2022, the baseline utilized = 2019
- For EQIP Entity's entering in **PY2+**, **2023**, the baseline utilized = 2022, or year preceding the PY

Updates to the baseline after three years will be discussed with stakeholders and developed in future performance years.

### 5. Reconciliation

### **5.1 Overview of Reconciliation Process**

Performance period episodes are constructed and attributed to Care Partners in the same manner as they were for the baseline period (**Section 3**). Reconciliation to determine if savings are created will be performed across the EQIP Entity, in the aggregate, across all episodes of participation for each clinical episode category. A clinical episode category generates savings if the performance total relevant costs are less than applicable target prices times the performance year volume. A clinical episode category generates



dissaving if the total relevant episode costs exceeds the aggregate of target prices for the performance year volume.

An EQIP Entity's incentive payment will be calculated based on savings generated, after validating the Minimum Savings Thresholds are met (**Section 5.2**) applying a Shared Savings Rate (**Section 6**) and adjusting for the EQIP Entity's Quality Adjustment Score (**Section 7**). Incentive payments are calculated in accordance with Maryland's agreement with CMS.

### 5.2. Minimum Savings Threshold

Minimum savings thresholds (MSTs) are important to ensure that the State rewards incentive payments judiciously. MSTs mitigate the risk that the State awards incentive payments based on chance fluctuations in costs rather than actual care transformation. The MST for EQIP establishes the percentage of savings that an EQIP Entity must first achieve before the EQIP Entity is eligible to receive incentive payments. Once the MST is met, the EQIP Entity will be eligible to receive "first-dollar" savings, subject to the shared savings rate described in **Section 7**. In other words, if the MST is met, then the total amount that the EQIP Entity 'saved' during the PY will be counted when calculating the incentive payment. The HSCRC may adjust the MST as needed to maintain program integrity and increase savings achieved with EQIP.

**The MST for EQIP PY1 is** *three percent*. An EQIP Entity's total episode costs during the PY (across all clinical episodes and categories) is compared to the EQIP Entity's aggregated target price (ATP), which is calculated as follows:

- Calculate the ATP. For each clinical episode category in which the EQIP Entity participates, multiply the EQIP Entity's final target price by the number of clinical episodes the EQIP Entity's Care Partner's were attributed during the PY.
- 2. **Determine Performance Year Costs.** Sum the performance year costs for all clinical episodes calculated across all clinical episode categories in which the EQIP Entity participates.
- 3. Determine Performance Year Savings. Subtract performance year costs (2) from the ATP (1)
- Compare the ATP to the Performance Year Costs. The EQIP Entity's performance year savings

   (3) must meet or exceed *three percent* of its ATP (i.e., the ATP multiplied by .03) before it is eligible to receive incentive payments.

### **5.3. Dissaving Policy**

The HSCRC will not incorporate downside risk in EQIP because it does not have the ability to directly adjust physician FFS payments. However, it is important for the HSCRC to ensure that EQIP drives meaningful improvements in cost efficiency and quality and maintains fidelity to national QPP standards. EQIP Entities



are held accountable for dissaving, year over year, to incentivize efficiency and quality improvement. There are two components of EQIP's Dissaving policy:

- 1. **Annual Accountability**: EQIP Entities who generate dissaving in a PY will be required to offset that dissaving in the following PY, prior to earning an incentive payment.
- Removal Accountability: An EQIP Entity will be removed from EQIP if it generates dissaving in two consecutive PYs and its performance across all clinical episode categories in which it participates ranks in the lower two terciles of the Tiered Shared Savings Rate (see Section 6). This policy and determination process is discussed further in Section 10.1.

### **5.4 Reconciliation Calculation**

Reconciliation to determine if a positive amount of savings is generated for eligibility of a shared savings split (**Section 6**) will calculate as follows:

- 1. Determination of savings.
  - a. Sum positive amounts by which the aggregate Performance period costs for each clinical episode category are below the final Target Price, across all clinical episode categories.
  - b. Sum negative amounts by which aggregate Performance period costs for each clinical episode category are above the final Target Prices, across all clinical episode categories.
  - c. Sum (1a) and (1b); if the amount is positive then savings are generated. If the sum of (1a) and (1b) is negative then dissavings are generated, evaluate dissaving policy and do not proceed with following steps (Section 5.3)
- 2. Check if MST is met (Section 5.2)
- 3. Offset prior year dissavings (if any).
  - a. Subtract Dissavings from the Prior Performance year, i.e. an aggregate negative sum from the prior year's reconciliation, from total savings determined (1c)
- 4. **Determine savings applicable to shared savings.** The resulting sum from (3a) that meets the check in (2) will be the amount in which shared savings is applied (**Section 6**), quality adjustments proceed (**Section 7**) and the Final Incentive Payment is determined (**Section 9**)

### 6. Tiered Shared Savings Rate

EQIP Entities and Medicare will share the savings generated by the EQIP Entities during the PY. The incentive payment to an EQIP Entity will be a portion of its calculated reconciliation amount. The portion paid to an EQIP Entity will be tiered, based on the EQIP Entity's relative efficiency in the clinical episode category in which they participate, compared to historical data on the same clinical episodes within the same category that were triggered statewide. The intent of a tiered shared savings rate is to provide low-



cost, high efficiency EQIP Entities with an opportunity to keep more savings when episodes have already been relatively optimized; while providing high-cost, low-efficiency EQIP Entities with an incentive to improve towards its peers' level of efficiency.

For each clinical episode category in which an EQIP Entity participates, the EQIP Entity's specific episode costs will be ranked with episode costs for all other providers triggering that clinical episode category in the state. The EQIP Entity will receive a single "blended" ranking based on combining its ranks in each clinical episode category's in which it participates. Higher costs will result in a lower percentile ranking and lower costs will result in a higher percentile ranking.

The following Shared Savings Rates will be applied based on the tercile in which an EQIP Entity's blended performance falls:

- Tercile 1 (1<sup>st</sup> 33<sup>rd</sup> percentiles): 50% savings paid to EQIP Entity / 50% savings paid to Medicare
- Tercile 2 (34<sup>th</sup> 66<sup>th</sup> percentiles): 65% savings paid to EQIP Entity / 35% savings paid to Medicare
- Tercile 3 (67<sup>th</sup> 100<sup>th</sup> percentiles): 80% savings paid to EQIP Entity / 20% savings paid to Medicare

### 6.1. Statewide Ranking Methodology

Statewide Ranking of an EQIP Entity's blended performance will be determined prior to the start of the PY1, based on baseline data on the types of EQIP episodes in which it chooses to participate.

The steps are as follows:

- 1. Within each clinical episode category, determine the individual Care Partners' statewide ranking with respect to average episode cost.
  - a. Use clinical episode-level data from the baseline period to create a statewide cost distribution
    - i. Drop Care Partners/NPIs with <11 episodes within the clinical episode category to ensure the distribution is based on providers with sufficient volume for stability
    - ii. Calculate the average episode costs for each care partner within each clinical episode category using the remaining providers with volume > 11
    - iii. Set the bottom of the distribution (0) equal to the average cost for the highest-cost provider and the top of the distribution (100) equal to the average cost of the lowest-cost provider within that episode category
    - iv. Use the remaining provider-level average episode costs to establish the percentile rank distribution between the highest and lowest cost providers.
  - b. For all NPIs (regardless of volume), define a value 'NPI\_Rank\_Clinical\_Category' as the NPIs percentile rank against the percentile distribution created in (1a)



- If a Care Partner's average baseline costs falls outside of the distribution created in (1b) set the percentile to 0 or 100, depending on if the baseline cost is lower (100) or higher (0) than the end of the distribution.
- If a Care Partner's (with less than 11 episodes) average baseline costs fall between two percentile values in the established distribution, use linear interpolation between the values to determine their exact NPI\_Rank\_Clinical\_Category.
- 2. Within each clinical episode category, determine the EQIP Entity's aggregate average ranking:
  - a. For each Care Partner/NPI [Attributed Provider ID], multiply their total baseline volume of episodes [Episode\_Count] by their 'NPI\_Rank\_Clinical\_Category'
  - b. Sum the total baseline volume [Episode\_Count] across all of the EQIP Entity's Care Partners for that clinical episode category.
  - c. Divide the result from (2a) by the result from (2b) to determine the EQIP Entity's average ranking 'EQIP\_Entity\_Rank\_Clinical\_Category.'
- 3. Calculate the final tiered shared savings rate ranking across all EQIP episodes in which the EQIP Entity elected to participate, weighted by episode volume:
  - a. For each type of EQIP episode, multiply the 'EQIP\_Entity\_Rank\_Clinical\_Category' by the total baseline episode volume determined in (2b).
  - b. Sum the result from (3a) across all EQIP episodes in which the EQIP Entity participates.
  - c. Sum the result from (2b) across all EQIP episodes in which the EQIP Entity participates.
  - d. Divide the result from (3b) by the result from (3c) to obtain the final, blended performance ranking, or 'EQIP Entity Rank Percentile.'
- 4. Compare this final EQIP Entity Rank Percentile to the Tercile Thresholds described above to determine the shared savings rate for that EQIP Entity for the selected performance year.

### 6.2. Updating the Tiered Shared Savings Rate Rankings

EQIP Entities will be re-ranked each PY based on their relative improvement in the clinical episode categories in which they participate and adjustments to their lists of Care Partner participants. This ranking will be based on the most recent year of performance for continuing participants and the baseline year for new participants (the year prior to participation)<sup>12</sup>, as illustrated in **Exhibit 8**.

#### Exhibit 8. Schedule for Tiered Shared Savings Rate Ranking

<sup>&</sup>lt;sup>12</sup> Note: that while the year used for ranking moves forward, the baseline period used in the savings calculation is fixed for three years (as described in Section 4.4), thus, an EQIP Entity can gain a greater share while maintaining their original baseline.



Program Year (PY)	EQIP Entity A (Joined in PY1)	EQIP Entity B (Joined in PY2)	EQIP Entity B (Joined in PY3)
2022 (PY1)	Ranking Year = 2019	n/a	n/a
2023 (PY2)	Ranking Year = 2022		n/a
2024 (PY3)	Ranking Year = 2023		

### 7. Composite Quality Score Adjustment

After the Shared Savings Rates are determined for each EQIP Entity, the resulting savings paid to the EQIP Entities will be subject to the Composite Quality Score (CQS) adjustment. Quality adjustment is required as a part of EQIPs APM status. By tying payment to performance on quality measures, EQIP incentivizes providers to improve quality of care while also improving efficiency.

EQIP will include a five percent "earn-back" adjustment on incentive payments. After the Shared Savings Rate is applied, the incentive payment is reduced five percent, and 0-100% of that five percent withholding will be returned to the EQIP Entity based on its quality performance. For each EQIP episode in which the EQIP Entity participates, up to five quality measures (3 will be used in PY1) will be weighted to calculate a CQS, which will then determine the amount of the incentive payment earned back for quality performance.

### 7.1. Overview of Quality Measures

For PY1, all EQIP episodes will be subject to three quality measures, regardless of type or clinical specialty area. The HSCRC chose quality measures with the following characteristics:

- Up to date in MIPS and applicable at the individual physician level
- Measurable using claims (i.e., no submission requirements for EQIP Entities)
- High-priority and outcomes-based (in MIPS and the National Quality Forum, NQF)
- Agnostic to the type of clinical episode and specialty area to avoid low cell-sizes and resulting variability
- Aligns with the Maryland Statewide Integrated Health Improvement Strategy.<sup>13</sup>

For each attributed episode, the HSCRC will assess whether the three measures defined in **Exhibit 9** were performed, *by any physician*, within 364 days preceding the end of the episode.

#### Exhibit 9. Quality Measures applied to all EQIP Episodes and Clinical Episode Categories

<sup>&</sup>lt;sup>13</sup> HSCRC. (December 2020) Statewide Integrated Health Improvement Strategy Proposal. Accessed June 28, 2021: <u>https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf</u>



Measure Name	Description	CPT Codes
Advance Care Plan ( <u>NQF #326</u> )	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record, <b>or</b> documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	99497 99498 1123F – tracking code, non-billable 1124F – tracking code, non-billable
Documentation of Current Medications in the Medical Record ( <u>NQF #419</u> )	Percentage of visits for patients aged 18 years and older for which a clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter	G8427 G8430 1159F – tracking code, non-billable
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan ( <u>MIPS #128</u> )	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter	G8422 G8938*

\* For the BMI measure, the denominator mentioned in step (1e) in **Section 7.3.1** will be adjusted downward to account for documented exceptions (G8438). The numerator tabulation will also exclude these instances.

### 7.2. CQS Performance Measurement

For PY1, the CQS will be based on the three quality measures, as noted in **Section 7.1** (after PY1, the CQS will be based on a set of up to five quality measures). The CQS adjustment is calculated as follows:

- 1. Score by Quality Measure: Each quality measure will be scored at the EQIP Entity level, and will be worth up to 10 points (see Section 7.3).
- 2. Determine Aggregate Measure Score: An EQIP Entity can receive up to 30 points (3 measures \* 10 points each) for PY1.
- 3. Convert Aggregate Score to Percentile for CQS: The CQS will equal the sum of the points earned on all applicable quality measures for the PY, divided by the maximum number of points available for the PY. The CQS will be calculated at the EQIP Entity level, and will be expressed as a percentage ranging from 0 to 100.

### 7.3. Statewide Scaling and Performance Thresholds

The process of assigning quality points to each quality measure, called "scoring," will be based on the EQIP Entity's quality performance during the PY, relative to set thresholds.



### 7.3.1. Performance Thresholds

Performance thresholds will be determined based on data from the 2019 Baseline EQIP episodes. The methodology for setting performance thresholds with which to compare performance year experience/episodes is as follows:

- 1. Determine Each Care Partner's Baseline Performance.
  - a. Limit to baseline episodes by NPI. Each Baseline episode [MasterEpisodeID] will be attributed to a Care Partner (NPI) [AttributedProviderID] as described in Section 3.6.3.
     Data on all beneficiaries who triggered an EQIP episode during the Baseline will be used to determine the Baseline performance of every Care Partner attributed an episode.
  - b. Find quality measure codes. For each quality measure, and each Baseline episode [MasterEpisodeID], all of the beneficiary's carrier and outpatient claims, with service dates on or between the episode end date and 364 days prior to the episode end date, will be used to count and flag the CPT/HCPCS codes from the list of CPT/HCPCS codes associated with the measure (see Exhibit 9).
  - c. Set episode-specific quality measure value: For each Baseline episode [MasterEpisodeID], the 'Quality Measure Flag' will equal one if the count of quality measure-specific CPT/HCPCS is greater than or equal to one, otherwise, the Quality Measure Flag will equal zero.
  - d. **Account for duplicate measures:** Beneficiaries [MemberID] may initiate more than one episode during Baseline, in which case a quality measure flag will be created for each episode, as described in (1c). Each episode will be included in the numerator of the performance rate calculation. The performance period of the two episodes may overlap when this occurs.
  - e. **Determine Care Partner Baseline Performance Rate:** For each Care Partner [AttributedProviderID], the 'Care Partner Measure Performance Rate' is calculated as the sum of 'Quality Measure Flag' determined in (1c) divided by the number of all baseline episodes [MasterEpisodeID]:

 $Perfomance Rate_{Care Partner} = \frac{\sum Measure Flag}{Total \ count \ of \ episodes^{14}} * 100$ 

<sup>&</sup>lt;sup>14</sup> For the BMI measure, the denominator will be adjusted downward to account for documented exceptions (G8438). The numerator tabulation will also exclude these instances as well.



- 2. **Determine Performance Thresholds.** For each quality measure, the distribution of performance rates for all Baseline Care Partners will be used to determine the performance thresholds specific to each quality measure, as follows:
  - a. *The 80<sup>th</sup> percentile value* of the baseline distribution will constitute the top threshold, and performance year scores at the 80<sup>th</sup> percentile benchmark or above will receive the maximum points (10 points).
  - b. *The 20<sup>th</sup> percentile value* will constitute the bottom threshold, and performance year scores below the 20<sup>th</sup> percentile benchmark will receive zero points.
    - Participants receiving performance scores below the 20<sup>th</sup> percentile benchmarks will be on probation. Two consecutive years of probation will result in automatic exclusion from EQIP (see Section 10 for further detail).
    - ii. Performance year scores equal to or higher than the 20<sup>th</sup> percentile benchmark and lower than the 35<sup>th</sup> percentile benchmark will receive zero points, but they will NOT constitute grounds for probation.
  - c. *Performance year scores equal to or above the 35<sup>th</sup> percentile* benchmark will receive positive points, as detailed in **Exhibit 10**.

Quality Performance Rate (PR)	Performance Year Points Assigned	Quality Probation
PR < 20 <sup>th</sup> Percentile	0	YES
20 <sup>th</sup> Percentile ≤ PR < 35 <sup>th</sup> Percentile	0	NO
35 <sup>th</sup> Percentile ≤ PR < 40 <sup>th</sup> Percentile	1	NO
40 <sup>th</sup> Percentile ≤ PR < 45 <sup>th</sup> Percentile	2	NO
45 <sup>th</sup> Percentile ≤ PR < 50 <sup>th</sup> Percentile	3	NO
50 <sup>th</sup> Percentile ≤ PR < 55 <sup>th</sup> Percentile	4	NO
55 <sup>th</sup> Percentile ≤ PR < 60 <sup>th</sup> Percentile	5	NO
60 <sup>th</sup> Percentile ≤ PR < 65 <sup>th</sup> Percentile	6	NO
65 <sup>th</sup> Percentile ≤ PR < 70 <sup>th</sup> Percentile	7	NO
70 <sup>th</sup> Percentile ≤ PR < 75 <sup>th</sup> Percentile	8	NO
75 <sup>th</sup> Percentile ≤ PR < 80 <sup>th</sup> Percentile	9	NO

#### Exhibit 10. Quality Measures Scoring



#### 7.3.2. Performance Year Scoring

To determine the PY points earned for each quality measure, the following steps will be followed:

- 1. Calculate the performance year quality rate for each episode at the EQIP Entity Level.
  - a. Performance rates will be calculated at the EQIP Entity [EQIPID] level using Medicare CCLF claims and Prometheus episode grouper output. For each EQIP Entity, data for all the beneficiaries [MemberID] who initiate an EQIP episode [MasterEpisodeID] during the PY will be used. For these beneficiaries [MemberID], all the non-denied carrier and outpatient claims from the 364 days prior to and including the episode end date will be analyzed.
  - b. Find quality measure codes: For each quality measure, at the episode level [MasterEpisodeID], the presence of a CPT/HCPCS code from the list of CPT/HCPCS codes associated with the measure (as described in Exhibit 9) will be counted and flagged.
  - c. **Set episode-specific Quality measure performance value:** The 'Performance Quality Measure Flag' will equal one for an episode if the measure-specific count is equal to or greater than one, otherwise it will equal zero.
    - If a beneficiary [MemberID] initiates more than one episode during a PY, each episode [MasterEpisodeID] will receive a measure CPT count and a measure flag, calculated as described above, and will be included in the performance year rate.
  - d. *Calculate EQIP Entity quality performance year rate:* For each measure, the performance year rate ('ACP Performance Rate', 'Medicine Performance Rate' 'BMI Performance Rate') will be calculated as:

 $Perfomance \ Rate_{EQIP \ Entity} = \frac{\sum Measure \ Flag}{Total \ count \ of \ episodes^{15}} * 100$ 

e. **Determine the EQIP Entity's total quality score.** For each EQIP Entity [EQIP ID], determine the total PY quality measure scores ('EQIP Entity Performance Year Score'), which will indicate the number of points earned, by comparing each quality measure performance rate ('ACP Performance Rate', 'Medicine Performance Rate' 'BMI Performance Rate') with the performance thresholds described in **Exhibit 10** to derive

<sup>&</sup>lt;sup>15</sup> For the BMI measure, the denominator will be adjusted downward to account for documented exceptions (G8438). The numerator tabulation will also exclude these instances as well.



'Total Points ACP Performance', 'Total Points Medicine Performance' and 'Total Points BMI Performance.'

### 7.4. Final CQS Determination

Once the performance rates have been calculated and the performance points for each measure have been determined, the CQS for each EQIP Entity will be calculated. The CQS will equal the total performance points earned across all the applicable measures divided by the maximum possible points for the PY.

For PY1, the CQS will be based on the three quality measures detailed in **Exhibit 9**. An EQIP Entity can receive up to 10 points for each measure, for a combined total of up to 30 points. The CQS for PY1 will be calculated as:

 $CQS_{PY1} = \frac{Total \ Points_{ACP \ Performance} + Total \ Points_{Doc.Med \ Performance} + Total \ Points_{BMI \ Performance}}{30} * 100$ 

### 7.5 Updating the CQS Statewide Scaling and Performance Thresholds

The CQS Statewide Scaling and Performance Thresholds will be calculated using the initial baseline year for the EQIP Entity's entrance into the program for the first three years of EQIP participation.

- For EQIP Entity's entering in **PY1**, **2022**, the baseline utilized = Statewide 2019 experience
- For EQIP Entity's entering in **PY2+**, **2023**, the baseline utilized = Statewide 2022, or year preceding the PY

Updates to the baseline after three years will be discussed with stakeholders and developed in future performance years.

### 8. Incentive Payment Cap (Stop Gain Amount)

The Incentive Payment after CQS adjustment will be assessed for a stop-gain amount, or Incentive Payment Cap. The cap for a Care Partner's incentive payments is calculated by CMS for a given PY based on the average Physician Fee Schedule (PFS) payments made to the Care Partner in the prior year. Per the Participation Agreement, the Care Partner Incentive Payment Cap is 25% of the Average Care Partner PFS Expenditures for the preceding calendar year.

The Incentive Payment Cap is calculated by CMS by:

 CMS shall notify the HSCRC of the Physician Incentive Payment Cap (no more than 25% of the prior year's Part B services) for each Care Partner enrolled in EQIP for the Performance Period by the deadline specified in the CRP Calendar.<sup>16</sup>

<sup>&</sup>lt;sup>16</sup> https://hscrc.maryland.gov/Documents/Modernization/CRP%20Calendar%20PP6%20Final.pdf



2. If the sum of the Incentive Payment Caps for Care Partners in an EQIP Entity is exceeded by the EQIP Entity's Incentive Payment due, the EQIP Entity will only receive the cap amount for the performance year.

### 9. Final Incentive Payment Calculation and Distribution

After performance reconciliation (**Section 5**), application of the tiered shared savings rate (**Section 6**), CQS adjustment (**Section 7**) and the incentive payment cap is checked (**Section 8**), a final Incentive Payment due to the EQIP Entity is determined.

- The incentive payment will be paid in total to the EQIP Entity no later than seven months after the end of the performance period.
- The incentive payment will be paid to the payment remission recipient indicated in EEP during the EQIP Entity's enrollment.

### **10. Removal from the Program**

EQIP is a voluntary program that will require an initial CPA and annual consent to participate thereafter. EQIP Entities are expected to maintain updated Care Partner documentation in the CRISP EEP. Should a Care Partner wish to be removed from an EQIP Entity, or an EQIP Entity no longer wish to participate in EQIP altogether, they will be required to update the HSCRC via the EEP within the annual enrollment window from 7/1-12/31, annually. EQIP Entities cannot be removed from the program during a current PY.

There are three circumstances where an EQIP Entity or Care Partner will be involuntarily removed from the program:

- If, during any period, the EQIP Entity's target price for the episode is in the lower two terciles of the Tiered Shared Savings Rate (0-66<sup>h</sup> percentile of Statewide Target Prices) and the provider had dissaving in the immediately preceding performance period, a second consecutive year of dissaving will result in removal from the program.
- Minimal quality performance, as described in Section 7.3.1 above
  - If the PY performance rate for the EQIP Entity is below the 20th percentile benchmark threshold, the EQIP Entity will receive zero points for that measure AND will be on probation for the PY. Two consecutive PYs on probation will result in automatic exclusion from EQIP, as noted in Section 7.
- Failure to maintain vetting and certification from CMS will result in a Care Partner's removal from the program.



• Failure to provide care or compliance in conjunction with the CPA will result in a Care Partner's removal from the program.



### **Appendix A. Update Factor Calculation**

The baseline data used to construct episodes will be trended forward to the performance period utilizing annual fee schedules and HSCRC rate update factors in order to be comparable to performance year costs. This will update baseline episode costs, accounting for inflation, market basket updates, or pertinent policy changes between the baseline and performance periods.

Claims included in the baseline costs will be split into two groups, Regulated Payments and Unregulated Payments. Unregulated payments will be split further, into six settings: IPPS (unregulated, if any), PFS, IRF, SNF, HHA, and Other. Unregulated OPPS will be included in Other.

### A.1 Unregulated Payments

- 1. All unregulated settings will be updated for inflation using the CMS market basket update factors by prospective payment system setting. In summary:
  - a. Assign annualized CMS market basket update factors to each included CCLF claim based on the claim type and corresponding prospective payment system (PPS) for all unregulated payments.
  - b. Exclude claims associated with payment settings that are regulated under the Maryland Total Cost of Care Waiver. These will be inflated separately as described under Section A.2 below.
  - c. All claim payments that cannot be assigned a setting-specific update factor will be inflated using the Medicare Economic Index value.
  - d. Cumulate the annual update factors for each year between the baseline and performance period for each setting and multiply this final inflation factor by the paid amount for that claim or claim line as appropriate.
  - e. Replace the reported paid amount for that claim with the final inflated paid amount calculated in (1d) above.<sup>17</sup>
  - f. Inflate regulated payments as described below and likewise replace the paid amounts on these claims with the inflated, standardized amount described below.
  - g. Recombine the unregulated and regulated claim payments into the final pre-processed CCLF dataset for input into the Prometheus episode grouper.

### A.2 Regulated Maryland Hospital Payments

<sup>&</sup>lt;sup>17</sup> https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-

Reports/MedicareProgramRatesStats/MarketBasketData



- 1. All regulated setting (IPPS and Hospital OPPS for MD Regulated Hospitals) will be standardized using the CMS Standardization Methodology for Allowed Amount,<sup>18</sup> inflated and renormalized to derive an inflation adjusted amount.
  - a. Standardized amounts will be derived by standardizing actual paid amounts using the version of the CMS Standardization Methodology current to the year of the program, using input values from the selected Baseline Period. For EQIP 2022 participation, the Program Baseline Period is 2019.
  - b. The calculation will be done at a hospital level based on total paid (CMS paid and cost share) and the final amounts will be reallocated between CMS paid and cost share.
  - c. For each hospital the HSCRC will calculate the Standardization Ratio as the ratio of Actual Paid to Standardized Allowed in the Program Baseline Period.
    - i. Formula: Actual Paid / Standardized Allowed
    - ii. Example: if MD payments are \$100 in the Program Baseline Period and the standardized amount is \$60, then the Standardization Ratio is 100 / 60 = 1.66.
  - d. For each period calculate the Cumulative HSCRC Inflation as the Cumulative HSCRC Inflation for the prior year times (1 + the Current Year Update Factor).
    - i. The Program Baseline Period Cumulative HSCRC Inflation factor will be deemed to be 1.0.
  - e. Calculate the Inflation Adjusted Actual Paid for the baseline period (the Target Price) and the performance period (the Adjusted Actual). Calculation is:
    - i. Calculate Standardized Allowed for each relevant period.
    - ii. Inflate the Standardized Allowed amounts by multiplying them by the Cumulative HSCRC Inflation Factor for the performance period. (Because the Standardized Allowed always reflects the Program Baseline Period amount via the baseline period input parameters, it is always appropriate to apply the full Cumulative HSCRC Inflation Factor.
    - iii. Convert the inflated, standardized amount to the Inflation Adjusted Actual Paid by multiplying by the Standardization Ratio for that hospital.
    - iv. This amount is then added back into the non-regulated inflated episode total calculated above to arrive at the total episode amount / target price as appropriate.
  - f. Episode performance will be derived based on comparing the Target Price to the Adjusted Actual.

<sup>18</sup> 

https://resdac.org/sites/datadocumentation.resdac.org/files/CMS%20Part%20A%20and%20Part%20B%20Price%20%2 8Payment%29%20Standardization\_Detailed%20Methods\_2.pdf

